PATIENT INFORMATION/COMPUTER FORM

(Ages 19 and Over)

CLINIC DATE:_____

NAME:_____

ADDRESS:_____
Street or P.O. Box City Zip

PHONE: _____ SEX:_____ DATE OF BIRTH:_____ AGE: _____

EMPLOYER:_____

PHYSICIAN: _____

ALLERGIES:_____

PREVIOUS SERIOUS VACCINE REACTIONS:_____

IF REQUESTING TB SKIN TEST, RESULTS OF PREVIOUS SKIN TEST: Negative ____ Positive____ Date:_____

1. RACE: (OPTIONAL) **Please √:** ☐ Caucasian ☐ Asian/Pacific Islander ☐ Hispanic ☐ Black
☐ American Indian/Alaskan Native ☐ Unknown ☐ Other

FOR NURSES USE ONLY:

MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #
HEP A 1 2 *SITE:* RDIM LDIM	**HEP B** 1 2 3 4 *SITE:* RDIM LDIM	**HEP B** *TITER* Positive Negative **RESULT**	**TWINRIX** ***(Hep A & B)*** 1 2 3 *SITE:* RDIM LDIM	**Td** 1 2 3 *SITE:* RDIM LDIM	**TdaP** **Boostrix** **Adacel** (10-18 YRS) (11-64 YRS) *SITE:* RDIM LDIM	**MMR** 1 2 *SITE:* RASQ LASQ	**PNEUMONIA** 1 2 *SITE:* RDIM LDIM

MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #
VARICELLA 1 2 *SITE:* RASQ LASQ	**IPV** 1 2 3 4 *SITE:* RASQ LASQ	**YELLOW FEVER** 1 2 *SITE:* RASQ LASQ	**TYPHOID** 1 2 *SITE:* RDIM LDIM ORAL	**TB** *SITE:* LAV	**TB RESULTS** Positive Negative _____ mm Checked by: _____	**MENINGOCOCCAL MENINGITTIS** 1 2 *SITE:* **Menactra** **Menomune** (11-55 yrs) LDIM RASQ RDIM LASQ

MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	**Nurses Signature**:_____
FLU *SITE:* LDIM RDIM	**FLUMIST** 1 Intranasally	**RABIES** 1 2 3 *SITE:* LDIM RDIM	**HPV** (9 – 26 YRS) 1 2 3 RDIM LDIM	**ZOSTAVAX** *1 (> 60 YRS)* *SITE:* LDSQ RDSQ	**Date**:_____ **Comments:**

Recall Date:_____

Name:_____

ACKNOWLEDGEMENT AND CONSENT – PLEASE INITIAL

_____ I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction.

_____ I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named above for whom I am authorized to make this request.

_____ I have received and reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures.

_____ I consent to the shared use of demographic information that is provided for immunization health purposes.

The following questions will help us determine which vaccine may be given in clinic today. Please answer these questions by checking the boxes. If the question is not clear, please ask the nurse to explain it.

	YES	NO	DON'T KNOW
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, eggs, any vaccine or any vaccine component? ☐ Gelatin (Varicella, Yellow Fever) ☐ Neomycin (MMR, IPV, Varicella) ☐ Streptomycin/Polymixin B (IPV) ☐ Thimerosol (a mercury derivative) (Flu) ☐ Latex (Flu) ☐ Yeast (HPV, Hep B)	☐	☐	☐
3. During the past year have you received a transfusion of blood or plasma,organ or stem cell transplant or been given a medicine called immune globulin?	☐	☐	☐
4. For women: Is it possible that you are pregnant or may become pregnant in the next month?	☐	☐	☐
5. Have you had any live virus vaccine in the past 30 days (measles, mumps,rubella, yellow fever, chickenpox)?	☐	☐	☐
6. Are you on Corticosteroids? (live vaccines)	☐	☐	☐

Did you bring your immunization record card with you? Yes ☐ No ☐

It is important for you to have a personal record of your shots. If you don't have a record card, ask your doctor or nurse to give you one! Bring this record with you to your clinic visits. Make sure your nurse records all your vaccinations on it.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Witness Date